

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814
(916) 445-6410



February 24, 1984

ALL-COUNTY LETTER NO. 84-28

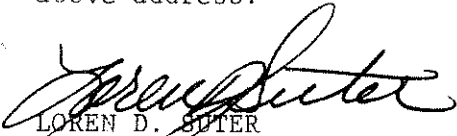
TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADULT SERVICES PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES RECIPIENT/EMPLOYER CHECKLIST,
REFERENCE: FORM SOC 332

The attached In-Home Supportive Services (IHSS) Recipient/Employer checklist has been developed as an optional form to assist agencies in informing IHSS recipients of their responsibilities as employers. Please use the attached sample as camera-ready copy for local reproduction if you choose to use this form.

A Spanish translation of the Form 332 will be sent in approximately one month.

The Department will not print and stock this form; however, additional copies for reproduction purposes may be requested from Pete Hilliard at (916) 322-8097. Please address all other program-related inquiries regarding this form and the instructions to your county consultant at the above address.


LOREN D. BUTLER

Deputy Director
Adult and Family Services Division

Attachment

cc: CWDA

**IN-HOME SUPPORTIVE SERVICES
Recipient/Employer Responsibility Checklist**

I, _____, HAVE BEEN INFORMED BY MY WORKER THAT AS A RECIPIENT/EMPLOYER, I AM RESPONSIBLE FOR THE ACTIVITIES LISTED BELOW:

- 1) To find, hire, train, supervise, and fire the provider(s) I employ.
- 2) To provide my worker with the following information regarding my provider(s), and any future change in my provider(s).

| | |
|----------------------------|--|
| — Name | — Telephone Number |
| — Address | — Relationship to me, if any |
| — Social Security Number | — Hours to be worked and services to be performed by each provider |
| — Date of Birth (if minor) | |
- 3) To inform my provider(s) that the hourly rate of pay is \$_____, gross and that Social Security and State Disability Insurance taxes may be deducted from the payment.
- 4) To inform my provider(s) that Federal or State Income Taxes will not be deducted from the payment and he/she will be sent a Form W-2 Wage and Tax Statement at the end of January for income tax filing.
- 5) To inform my provider(s) if he/she may be covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.
- 6) To inform my provider(s) of the services authorized and the time given to perform authorized services.
- 7) To pay my share of cost, if any, directly to my provider(s) or directly to the county social services department.
- 8) To verify and sign my provider(s) timesheet for each pay period showing the day and the number of hours worked.
- 9) To advise my provider(s) to mail his/her signed timesheet to the appropriate county social services department at the end of each pay period.
- 10) To comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

Note: Refer to Industrial Welfare Commission (IWC) Order 15-80 regarding wages/hours/working conditions obtainable from the State Department of Industrial Relations, Division of Labor Standards and Enforcement listed in the telephone book. Additional information regarding the hiring of minors may be obtained by contacting your local school district.

I HAVE EXPLAINED THE RESPONSIBILITIES LISTED ON THIS FORM TO THE IHSS RECIPIENT.

Worker

Telephone

Date

INSTRUCTIONS FOR USE OF THE RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST

1. This form is recommended for review with recipients receiving service from Individual Providers **only**.
2. Counties may use this form to assure that recipients have been advised of and understand their basic responsibilities as employers of IHSS providers.
3. Review each item with the recipient and explain how the recipient can comply with each requirement.
4. Sign and date the form.
5. Leave a copy of the form with the recipient.